ALCOHOL & SUBSTANCE ABUSE

Indian Health Service

Clinical Services	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Alcohol & Substance Abuse					
Budget Authority	$96,824,000	$130,254,000	$135,005,000	+$38,181,000	+$4,751,000
FTE	172	172	172	0	0
Services Provided:					
Outpatient Visits	590,000	750,000	750,000	+160,000	0
Inpatient Days	285,000	365,000	365,000	+80,000	0
Regional Trt Center:					
Admissions	3,700	4,700	4,700	+1,000	0
Aftercare Referrals	8,700	11,100	11,100	+2,400	0
Emergency Placements	390	500	500	+110	0

PURPOSE AND METHOD OF OPERATION

Program Mission/Responsibilities

The Alcoholism and Substance Abuse Program (ASAP) activities are part of a Behavioral Health Team that works collaboratively to eliminate the disease of alcoholism and other drug dependencies and the associated pain it brings to individuals of all ages, families, villages, communities, and tribes. The ASAP primary goal is to reduce the prevalence and incidence of alcoholism and other drug dependencies. The ASAP provides support and resources for AI/AN communities toward achieving excellence in holistic alcohol and other drug dependency treatments, rehabilitation, and prevention services for individuals and their families. In addition to the development of curative, preventative and rehabilitative services, the ASAP activities include:

- Development and coordination of an integrated information management system that measures substance abuse and alcohol problems among AI/AN;
- Programmatic evaluation and research toward developing effective prevention and treatment services;
- National leadership that focuses on youth treatment, community education, and prevention services for high-risk youth; and
- Services for children and adults with FAS and FAE.

The ASAP continues to provide services primarily through contracts with tribal entities/consortia, including tribes that have compacted under Self-Governance, and Indian-managed urban boards of directors since the passage of the Indian health Care Improvement Act, P.L. 94-437. Presently, the IHS funds approximately 300 AI/AN ASAPs that provide a multitude of treatment and prevention services to rural and urban communities.

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Best Practices/Industry benchmarks

Approximately 5 percent of the estimated 1,800 employees in IHS-funded ASAPs are Federal staff with Tribal staff comprising 95 percent. The credentialing, training, and hiring of 1,200 counselors have been a major initiative to address counselor competency. The counselor certification and professional licensure rates continue at approximately 85 percent of the program staff.

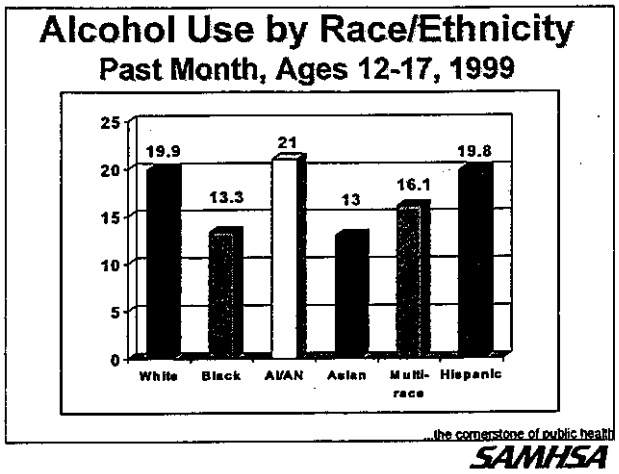
There are four YRTCs accredited by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) and four others that are accredited by Commission on Accreditation of Rehabilitation Facilities (CARF). Two of the three remaining facilities are state licensed/certified, and one of the facilities is currently preparing for CARF accreditation.

The tribal alcohol programs are state licensed and/or certified. The majority of the tribal alcohol programs follow the Indian Health Manual, Part III, Chapter 18, ASAP Standards that are modeled after JCAHO and CARF Standards.

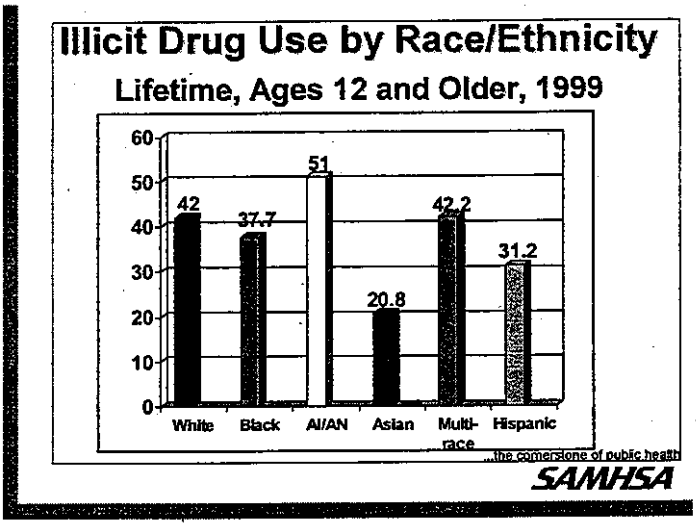
Correcting identified areas for improvement in residential and non-residential facilities requires additional resources to improve alcoholism and substance abuse programs. For example, an evaluation of the effectiveness of IHS sponsored aftercare/continuing care service is an underway though other program efforts remain to be evaluated when resources allow.

Findings Influencing FY 2002 Request

Alcoholism mortality for AI/ANs decreased from 59 per 100,000 in 1980 to 37.9 per 100,000 in 1991. The latest data, however, indicate that alcoholism mortality rates have worsened since 1992. When the 1992-1994 alcoholism death rate is adjusted for miscoding of Indian race on death certificates, it increases from 39.4 per 100,000 to 45.5 per 100,000, nearly 7 times the alcoholism death rate of the overall U.S. population. Similarly, the age-adjusted drug-related death rate for AI/ANs increased from 3.4 deaths per 100,000 in 1979-1981 to 5.3 in 1992-1994. The AI/AN drug-related death rate is 18 percent higher than the rate for the overall U.S. population. In an evaluation study of the Youth Regional Treatment Centers (YRTC), problem severity in AI/AN youth appears to be more treatment intensive in comparison to the general U.S. population as indicated by program completion rates of 53 percent versus 61 percent of the general population. Comprehensive care requirements favor dually trained staff in mental health and alcohol/substance abuse disorders to effectively and safely meet the needs of young people with dual diagnosis.

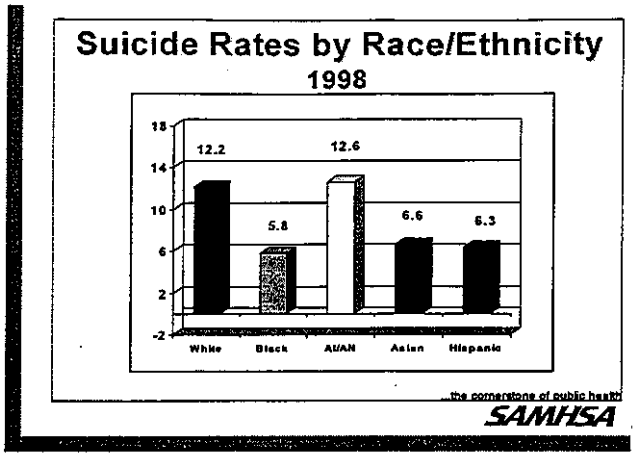


The 1999 Substance Abuse and Mental Health Services Administration (SAMHSA) data show that compared to all races and ethnic groups, AI/ANs Ages 12-17 have the highest alcohol use rates (Past Month).



Data for 1999 show that AI/ANs have the highest lifetime illicit drug use for ages 12 an older compared to all races and ethnic groups.

The high rates of alcohol and illicit drug use are significant as independent issues but alarming when joined with high suicide rates, as reflected in SAMSHA data for 1998 by race and ethnicity.



ACCOMPLISHMENTS

Interagency Activities

The IHS Alcoholism and Substance Abuse Program (ASAP) collaborated with Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Disease Control and Prevention (CDC), Health Care Finance Administration (HCFA), Bureau of Indian Affairs (BIA), Housing and Urban Development, Department of Transportation, and the Department of Justice (DOJ).

- Local community based training workshops and events called "Gathering of Native Americans," are being widely adapted throughout Indian Country. These workshops and events have been designed, tested, and evaluated in American Indian communities with the help of Indian education, social services and health professionals supported by both the IHS and the SAMHSA Center for Substance Abuse Prevention (CSAP). These workshops have revitalized community planning interest and capabilities for addressing alcoholism and substance abuse.

- Coordination with the Centers for Disease Control and Prevention to fund an injury management control officer and a tobacco education and training officer.

- Two IHS ASAP staff members work two days per week within the Center for Substance Abuse Treatment (CSAT) and the Center for Substance Abuse Prevention (CSAP) respectively. This cooperative effort has increased national consultation and collaboration for AI/AN behavioral health specifically around access to services through state block grants and competitive grant opportunities.

- Numerous clinics and hospitals in the Aberdeen Area are using the CDC developed Prenatal Health Assessment screening instrument for pregnant substance abusing women.

- IHS continues to fund Fetal Alcohol and Drug Unit mini-internships at the University of Washington for I/T/U providers.

- IHS worked with the Office of National Drug Control Policy, the Department of Transportation, Bureau of Indian Affairs, Department of Justice, and the Housing and Urban Development to co-sponsor and develop an Annual National Tribal Leaders Best Practices Substance Abuse Summit

in. The first summit occurred last year and plans are currently underway for a continuation of this activity.

Professional Development

- The IHS continues to support primary care provider training workshops to enhance professional skills in addiction, prevention, intervention, and treatment. A special module has been developed for public health nurses. Between 40 to 60 primary care providers receive this training each year Activities include the development of a lending library (video and slide materials) to improve provider in-service capability and community presentations.

- Counselor certification and professional licensure rates continue at approximately 85 percent of the program staff. New funding will be used, in part, to improve the rate of licensure and/or certification for IHS-funded ASAPs.

- Clinical supervision/training continues as in previous fiscal years to enhance counseling efforts.

Information Management

- Plans are underway to merge the Chemical Dependency Management Information System (CDMIS) with the Social Services and Mental Health reporting system. The data merger will provide more information on the full range of behavioral health issues facing the AI/AN people. Funds available in 2001 are being used to initiate data merger activities including assessment, equipment, and training.

- Previous CDMIS data management activities integrated commercial and RPMS data facilitating a behavioral health treatment model. The integrated data system is being tested in the Billings Area. The ASAP is supporting two software enhancement projects that further integrate and coordinate assessment, treatment planning, and case management utilizing the American Society of Addiction Medicine (ASAM) Patient Placement criteria and the CSAT Alcohol Severity Index (ASI). Systems are being tested at 10 YRTCs and in the Billings Area.

Fetal Alcohol Syndrome

- Leadership is being provided for the prevention of secondary disabilities in FAS individuals. While comprehensive data are not available, studies suggest that alcohol affected pregnancies are at least 10 times more frequent in AI/AN communities than in the broader population. A training manual was prepared in conjunction with the Jamestown S'Klallam Tribe for providers, parents, and caregivers of FAS children and adolescents. The IHS is responding to a high volume of requests for the manual as resources on FAS/FAE, particularly for AI/ANs, which are currently scarce.

- Funds were provided early in FY 2001 from a congressional earmark for SAMHSA to administer through the Center for Substance Abuse Prevention for an FAS/FAE project. The funds were awarded to a four-state consortium that includes Montana, North Dakota, South Dakota and Minnesota. Each state within the consortium is working on a state-

specific FAS/FAE plan. Over the next 2-3 years the consortium states will work together to identify high-risk populations, test interventions, and collect data. All citizens in the four states are a part of the target population, however, specific high-risk groups will be identified. It is expected that AI/ANs will figure into the high-risk populations for FAS/FAE.

Treatment for Women

- The IHS ongoing effort to evaluate alcohol and substance abuse treatment for AI/AN women resulted in a final report, dated, January 2001. The evaluation indicates that alcohol and substance abuse accounts for 25 percent of the deaths for AI/AN women and defines factors critical to successful treatment. Childcare is a significant factor in the alcohol treatment of AI/AN women. Plans are underway in IHS to address childcare and women's treatment in concert with the BIA.

Future Directions

The IHS actively cooperates with DHHS, and other agencies in developing policy research agendas, and data monitoring. The IHS seeks to reduce alcohol and drug abuse by using strategies that include:

- Continue implementation of a planned integration of RPMS and standardized commercial behavioral health software to enhance the treatment plans, evaluation of services, and improve third party reimbursement. Because the value of the information and data that would result from this effort is significant, it has been determined as the Behavioral Health priority.

- Research and evaluation of collaborative efforts and after-care evaluation.

- Continue development of a comprehensive continuum of care encompassing prevention, education, treatment and rehabilitation. Workshops on American Society of Addiction Medicine Patient Placement Criteria will be continued.

- Continue to support treatment and prevention for women and men.

- Support inhalant abuse prevention and treatment initiative as a gateway drug in children, including Head start, and young adolescents.

- Injury control projects, e.g., the DHHS' Healthy People 2010 objectives.

- Continue efforts in enhancement of counselor skills.

- Tobacco cessation programs.

- Expand primary prevention efforts via collaboration with the Center for Substance Abuse Prevention and other agencies.

- Coordinate with the BIA to work with the Tribes to review and update community plans and action items that address alcohol and substance abuse issues.

- Continue to work with States and other Federal agencies to assist Tribes in accessing available competitive grants that are effective in the AI/AN communities.

- Expand on previous work to determine resources needed to provide behavioral health services (an integrated model of mental health and substance abuse/alcohol programs).

- Expand on traditional healing efforts that are showing increasing benefit in many AI/AN communities.

- Continue enhancement of YRTCs development and effectiveness.

- Continue to enhance and improve aftercare services available to youth.

- Continue meetings to address the national adolescent inhalant abuse issue.

Participate with CSAT and the Administration for Children and Families to conduct four regional meetings for child welfare and substance abuse issues. Continue IHS/CSAP initiatives with Tribal Colleges and Universities and the three-year, tri-state FAS/FAE project in the Billings, Aberdeen, and Bemidji Areas. Expand the IHS Elder Care Initiative by broadening the assessment of AI/AN elders to include alcohol and substance abuse assessments.

PERFORMANCE PLAN

The following performance indicators are included in the IHS FY 2002 Annual Performance Plan. These indicators are sentinel indicators representing the more significant health problems affecting AI/AN. At the FY 2002 funding level, IHS would be able to achieve the following:

Indicator 9: During FY 2002, youths discharged from Regional Treatment Centers (RTC) will:

a. Receive follow-up equal to or greater than the FY 2001 level

b. Increase by at least 5 percent over FY 2001, the youths who have documented 6 months of less alcohol and drug use than before treatment

Indicator 10: During FY 2002, increase the proportion of I/T/U prenatal clinics utilizing a recognized screening and case management protocol(s) for pregnant substance abusing women by 5 percent over the FY 2001 level.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE	
1997	$91,482,000	184	
1998	$91,782,000	186	
1999	$94,680,000	175	
2000	$96,824,000	172	
2001	$130,254,000	172	Enacted

In H.R. 5666, "Miscellaneous Appropriations", as Actual by the Consolidated FY 2001 Appropriations Bill (HR 4577), Congress made a $15 million direct lump sum appropriation to the Alaska Federation of Natives (AFN) for its "Alaska Native Sobriety and Alcohol Control Program" that allows the AFN to make grants to each of the regional Alaska Native corporations to ban the sale, importation, and possession of alcohol pursuant to local option state law. An additional 15 million is provided to the IHS for the non-Alaska Tribes for drug and alcohol prevention and treatment services. A portion of the funds will be used to support the data consolidation project. The remainder of the funds will be distributed to each of the Areas to spend on alcohol and substance abuse priorities. These activities are continued in FY 2002.

RATIONALE FOR BUDGET REQUEST

Total Request -- The request of $135,005,000 and 172 FTE is an increase of $4,751,000 over the FY 2001 enacted level of $130,254,000 and 172 FTE. The increase includes the following:

Built-in Increases: +$4,751,000

The request of $4,255,000 for inflation/tribal pay cost and $496,000 for federal personnel related costs funds the built-in increases associated with on-going operations. Included is the FY 2002 pay raise and within grade increases. These funds will be shared with Title I and Title III tribes, as well as Federal programs.

It is extremely critical that the IHS maintains the FY 2001 level of service for American Indians and Alaska Natives. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between AI/ANs and the rest of the U.S. population.

ALCOHOLISM AND SUBSTANCE ABUSE PREVENTION/TREATMENT PROGRAM AUTHORIZED UNDER P.L. 103-572
(DOLLARS IN THOUSANDS)

Amount of Funds	FY 1993 Appropriation	FY 1994 Appropriation	FY 1995 Appropriation	FY 1996 Appropriation	FY 1997 Appropriation	FY 1998 Appropriation	FY 1999 Appropriation	FY 2000 Appropriation	FY 2001 Appropriation**	FY 2002 Request
Adult Treatment	$47,232	$49,566	$51,693	$51,693	$51,766	$51,936	$53,576	$54,789	$65,299	$67,681
Regional Treatment Centers	12,407	14,040	14,013	14,013	14,033	14,079	14,523	14,852	20,378	21,121
Community Education & Training	2,594	2,726	2,880	2,880	2,884	2,894	2,985	3,053	11,370	11,784
Community Rehabilitaiton/ Aftercare	11,880	13,593	15,088	15,088	15,109	15,159	15,638	15,992	24,776	25,680
Gila River		135	135	135	135	136	140	143	148	154
Contract Health Service	5,920	6,221	6,209	6,209	6,218	6,238	6,435	6,581	6,819	7,067
Navajo Rehab. Program	237	249	239	239	239	240	248	253	262	272
Urban Clinical Services	450	473	509	509	510	511	528	539	559	579
Wellness Beyond Abstinence	585	614	586	586	587	589	607	621	644	667
Total	$81,305	$87,617	$91,352	$91,352	$91,482	$91,782	$94,680	$96,824	$130,254	$135,005

URBAN HEALTH PROGRAM 1/

Amount of Funds	FY 1993 Appropriation	FY 1994 Appropriation	FY 1995 Appropriation	FY 1996 Appropriation	FY 1997 Appropriation	FY 1998 Appropriation	FY 1999 Appropriation	FY 2000 Appropriation	FY 2001 Appropriation	FY 2002 Request
Expand Urban Programs	2,828	2,972	3,044	3,045	3,045	3,048	3,180	3,239	3,367	3,491

INDIAN HEALTH FACILITIES 2/

Amount of Funds	FY 1993 Appropriation	FY 1994 Appropriation	FY 1995 Appropriation	FY 1996 Appropriation	FY 1997 Appropriation	FY 1998 Appropriation	FY 1999 Appropriation	FY 2000 Appropriation	FY 2001 Appropriation	FY 2002 Request
Construction	7,929	2,780	0	0	0	0	0	0	0	0

Alcohol/Substance Abuse	**$81,305**	**$87,617**	**$91,352**	**$91,352**	**$91,482**	**$91,782**	**$94,680**	**$96,824**	**$130,254**	**$135,005**
Urban Health Program	**2,828**	**2,972**	**3,044**	**3,045**	**3,045**	**3,048**	**3,180**	**3,239**	**3,367**	**3,491**
Facilities Construction	**7,929**	**2,780**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
GRAND TOTAL	**$92,062**	**$93,369**	**$94,396**	**$94,397**	**$94,527**	**$94,830**	**$97,860**	**$100,063**	**$133,621**	**$138,496**

**These amounts are subject to change as the distribution of the additional $30 million appropriated under Labor, HHS is pending consultation and approval by the Tribes.

1/ The Urban Program was funded under P.L. 100-690, and now is funded under P.L. 103-572.

2/ These funds included in the Outpatient Sub-sub-activity.

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